

VACCINES FOR CHILDREN (VFC) PROGRAM PROVIDER PROFILE FORM—SUPPLEMENTAL

		PIN (6 digit)	
		COUNTY	
NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC.		DATE	
ADDRESS (Number and Street)		CITY	ZIP CODE
CONTACT PERSON	EMAIL ADDRESS	TELEPHONE ()	FAX ()

LAST NAME, FIRST, MI	MEDICAID PROVIDER NUMBER (i.e., CHDP or Medi-Cal number)	MEDICAL LICENSE NUMBER	TITLE (e.g., MD, DO, NP, PA— Provider must have prescrip- tion writing privileges)	SPECIALITY (e.g., Peds, Family Med, GP, Other [Specify])
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Instructions: You must use this form to list all health care providers at your facility with prescription writing privileges who will administer VFC Program-provided vaccines. (You may use additional copies of this form to list additional providers.) Submit this form with the VFC Provider Profile Form.

Note: It is not necessary to include the names of all staff who may administer VFC vaccine, but rather only those who possess a medical license or are authorized to write prescriptions.

